FIRST MED
URGENT CARE

PATIENT HISTORY QUESTIONNAIRE

LAST NAME	FIRST NAME	MIDDLE INITIAL

DATE OF BIRTH	SEX M F

List any allergies you have including medications, food or any other negative reaction and type of reaction.

NKDA (no known drug allergies)

Allergies: _____

List any medications you are currently taking, including over the counter medication. Please list medication strength and how often you take the medication. NONE

Please Note: ***If you do not know the medication, please call your pharmacy. We are unable to provide care without a current medication list.***

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

PHARMACY INFORMATION

We may be able to send your prescription directly to your pharmacy. Please list the pharmacy where you want your prescription sent.

PHARMACY NAME	PHARMACY LOCATION

List all long term or recurring medical problems. NONE

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any kind of surgery you have had. NONE

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any pertinent medical problems in your family and identify who (i.e. Mother, Father, Brother, Sister). Mark NONE if you have no family medical problems. NONE

1. _____ 3. _____
   FAMILY MEMBER / CONDITION — FAMILY MEMBER / CONDITION
2. _____ 4. _____
   FAMILY MEMBER / CONDITION — FAMILY MEMBER / CONDITION

Do you smoke or use any tobacco products? ___ Never ___ I used to

___I smoke cigarettes ___cigars ___chew tobacco _____Quantity per day / week / month / year

Do you use recreational drugs? ___Never ___I used to ___I have used IV drugs

Current Use: What type?_____ How often? _____

Do you drink alcohol? ___ Never ___ I used to ___ I am in recovery

___I drink socially ___regularly _____Quantity per day / week / month / year

The following individuals are authorized to speak to FIRST MED regarding my health information.

_____ _____ _____

Name/Relationship Name/Relationship Name/Relationship

My signature below acknowledges that I have been given a chance to review a copy of the FIRST MED Urgent Care Notice of Privacy Practices.

PATIENT SIGNATURE _____ *RELATIONSHIP IF OTHER THAN PATIENT* _____